MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
OFFICE OF HUMAN RESOURCES

Administrative Policy 8.12
Attachment A

HEALTH CARE CERTIFICATION (Family & Medical Leave Act (FMLA) of 1993) For EMPLOYEE'S SERIOUS HEALTH CONDITION

EMPLOYEE SECTION		
EMPLOYEE FULL NAME (PRINT)	**EMPLOYEE'S SUPERVISOR**	**LAST FOUR (4) DIGITS OF SSN**

HEALTH CARE PROVIDER SECTION

PART A. – MEDICAL FACTS

1. MEDICAL CONDITION (include symptoms, diagnosis, or any regimen of continuing treatment):

IS THE MEDICAL CONDITION PREGNANCY? ☐ YES ☐ NO (If yes, answer following 3 questions and move to Part B)
DATE PRENATAL CARE COMMENCED: _____ EXPECTED DUE DATE: _____ WEEKS OFF POST-PARTUM: _____

2. APPROXIMATE DATE CONDITION COMMENCED: _____

3. PROBABLE DURATION OF CONDITION: _____

4. WAS THE PATIENT ADMITTED FOR OVERNIGHT STAY IN HOSPITAL OR CARE FACILITY? ☐ YES ☐ NO
DATE ADMITTED: _____ DATE RELEASED: _____

5. WILL THE PATIENT NEED TO HAVE TREATMENT VISITS AT LEAST TWICE PER YEAR FOR THIS CONDITION? ☐ YES ☐ NO
DATES OF SCHEDULED APPOINTMENTS (to be determined by healthcare provider): _____ and _____

6. WAS MEDICATION, OTHER THAN OVER-THE-COUNTER MEDICATION, PRESCRIBED? ☐ YES ☐ NO

PART B. AMOUNT OF LEAVE NEEDED

1. WILL THE PATIENT BE INCAPACITATED FOR A SINGLE CONTINUOUS PERIOD OF TIME DUE TO HIS/HER MEDICAL CONDITION, INCLUDING ANY TIME FOR RECOVERY AND TREATMENT? ☐ YES ☐ NO
IF SO, ESTIMATE THE BEGINNING AND ENDING DATES FOR THE PERIOD OF INCAPACITY? _____

2. WILL THE PATIENT NEED TO ATTEND FOLLOW-UP TREATMENT APPOINTMENTS OR WORK A REDUCED SCHEDULE? ☐ YES ☐ NO
IF SO, ESTIMATE TREATMENT SCHEDULE (include scheduled appointment dates)

IF SO, ESTIMATE THE REDUCED WORK SCHEDULE THE PATIENT NEEDS.
Number of hours per day:_____; _____ days per week from _____ through _____

3. WILL THE CONDITION CAUSE EPISODIC FLARE-UPS PERIODICALLY PREVENTING THE PATIENT FROM COMPLETING HIS/HER JOB FUNCTIONS? ☐ YES ☐ NO
IF SO, BASED ON PATIENT'S MEDICAL HISTORY AND YOUR KNOWLEDGE OF THE MEDICAL CONDITION, ESTIMATE THE FREQUENCY OF THE FLARE-UPS AND THE DURATION OF RELATED INCAPACITY THAT THE PATIENT MAY EXPERIENCE OVER THE NEXT 6 MONTHS (Example: 1 episode every 3 months for 1-2 days)
FREQUENCY: _____TIMES PER _____ WEEK/_____ MONTH
DURATION: _____ HOURS OR _____ DAYS PER EPISODE

4. IS THE EMPLOYEE UNABLE TO PERFORM WORK OF ANY KIND? ☐ YES ☐ NO – HOW LONG? _____

5. ARE THERE ANY WORK RESTRICTIONS? ☐ YES ☐ NO
IF SO, INDICATE NATURE OF RESTRICTIONS AND HOW LONG RESTRICTIONS ARE EXPECTED TO LAST.

THANK YOU FOR YOUR TIME AND ATTENTION IN COMPLETING THIS FORM!

HEALTH CARE PROVIDER SIGNATURE	HEALTH CARE PROVIDER NAME (PRINT)	DATE
TYPE OF PRACTICE	**PRACTICE ADDRESS**	**TELEPHONE NUMBER**